Welcome to Enchantment Dental

Date________________Home Phone(_____)_____________Cell Phone(______)_______________

Name_________________________________SS#_______________(Needed to file your insurance)

Address____City_________State___Zip Code__________

Gender: M F Age________Birthdate_________________E-mail_____________________________

Work Place____Work Phone(_____)________________

Emergency Contact__________________________________Phone(_____)___________________

Office and payment policies

1.We are happy to file all insurance paper work for you, however please know you are ultimately responsible for **all fees** incurred at this office. Co-payments from your insurance generally range from 50% to 80% for fillings and crowns with a $50 deductible. Most insurance companies cover x-rays, exams and cleanings at 100%. These are generalities, however your insurance may vary on its benefits.

2. **Estimated co-payments are due at time of service. If you are self pay patient payment at the time of service is required.** If you have any questions regarding the amount due, please feel free to ask prior to service being rendered. To ensure our ability to serve our patients, please do not ask us to finance any fees. We do accept Visa, Master card and Discover card payments. Returned check fee $25.00.

3. Cancellation of an appointment with less than 24 hours notice or missed appointment will add a $50.00 fee which is due before you will be reappointed without exception please do not ask.

4. Patients not seen for 18 continuous months will considered self dismissed. Non-payment of a missed or cancelled appointment fee for 90 days will also be considered self dismissed.

5. By signing below you acknowledge that you are aware of your financial obligation, and that you have received or read a copy of our office's HIPPA notice of our privacy practices. **By signing below you also assign your insurance benefits to be paid directly to our practice.**

6. Any disputes with our office are hereby remanded to binding arbitration and are excluded from civil litigation.

Signature____(Required)

Primary Insurance Information: If available please present any dental insurance cards to us for additional required information.

Insurance Company____

INFORMATION ABOUT INSURED PERSON:

Primary insured person____________________________Birhtdate______________SS#______________

Phone Number(_____)___________Insured person's employer_______________________________

Patient's relationship to insured person____

Patient Medical/Dental History
Patient Name:_______________________________________**DOB:**____________________

Current Medical Conditions	Current Medications Include over the counter & herbal	Allergies

1. **Name of Medical Doctor:** _______________________________
2. **Date of last medical treatment:** ____________________________________
3. **Do you have any of the following or have you had any of the following?** Yes or No
   - ___ Liver Disease (Hepatitis, Jaundice)
   - ___ Diabetes
   - ___ Lung Disease
   - ___ Brain Injury or Epilepsy
   - ___Cancer/Radiation treatment
   - ___ Bleeding Disorder
   - ___ Joint Replacement
   - ___ Infectious Disease (HIV, Tuberculosis)
   - ___ Heart Disease (Pacemaker, Heart murmur, Valve disease)
4. **Women Only:**
   1. Are you pregnant or think you may be? ☐ Yes ☐ No
   2. Are you nursing? ☐ Yes ☐ No
   3. Are you using Birth Control Pills or Patch? ☐ Yes ☐ No
5. **Do you smoke or chew tobacco?** ☐ Yes ☐ No How much? ________________________
6. **Dental History:**
   1. Do you have pain or concerns regarding your teeth, mouth, gums, or jaw? ☐ Yes ☐ No
   2. If you have pain, where is the pain? ____________________________________
   3. On a scale of 1-10 how severe is the pain?
      Mild 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10 Severe
7. **Have you had any problems with dental treatment?**

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I certify that I read and understood the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information is dangerous to my health.

Signature or Patient or Guardian:______________________**Date:**___________
Doctor's comments:

____

Patient reviewed date: _______________
Changes____
Signature:_________________________________

Patient reviewed date:_______________
Changes____
Signature:_________________________________

HIPPA Notice of Privacy Practices
Enchantment Dental, PC
1442 A St. Francis Drive   Santa Fe, NM 87505

This Notice Describes how medical Information about you may be used and disclosed and how you can get Access to this information. Please review it carefully.

1. Uses and disclosures of protected health care information:

A. Treatment: We will use and disclose your personal information to provide, coordinate, or manage your health care and related services. This includes communications with a third party such as insurance company or home health agencies.

B. Payment: Your protected information may be used to file insurance.

C. Health Care operations: Your protected information may be used in business activities such as quality assessment, training, licensing and other related business activities. These include phone messages in order to confirm treatment times and descriptions of treatment, unless you ask that these messages not be left.

Other disclosures made not in the context of your dental care and business relations may be made only with your consent.

2. Your Rights:

A. Your have the right to inspect and copy your protected health information. In most cases a written request for your records will require 72 hours to copy.

B. You have the right to request a restriction of your protected health information.

C. You have the right to receive confidential communications from us by alternative means or at an alternative location.

D. You have the right to have the Dentist amend your protected health information.

E. You have the right to receive an accounting of the certain disclosures we have made, if any, of your protected health information.

3. Complaints:

You may complain to us or the Secretary of Health and Human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact (Theo Krupp, Office Manager) of your complaint. We will not retaliate against you for filing a complaint.

Please take this notice with you

Notice effective June 1, 2005